

<i>SERFF Tracking Number:</i>	<i>PRUD-125850202</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Prudential Insurance Company of America</i>	<i>State Tracking Number:</i>	<i>40569</i>
<i>Company Tracking Number:</i>	<i>SNCTU-2001-JSAR</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.215 Specified Age or Duration - Fixed/Indeterminate Premium - Joint (Last Survivor)</i>
<i>Product Name:</i>	<i>SNCTU-2001</i>		
<i>Project Name/Number:</i>	<i>SNCTU-2001/</i>		

Filing at a Glance

Company: The Prudential Insurance Company of America

Product Name: SNCTU-2001 SERFF Tr Num: PRUD-125850202 State: ArkansasLH

TOI: L04I Individual Life - Term SERFF Status: Closed State Tr Num: 40569

Sub-TOI: L04I.215 Specified Age or Duration - Co Tr Num: SNCTU-2001-JSAR State Status: Filed-Closed
Fixed/Indeterminate Premium - Joint (Last
Survivor)

Filing Type: Form	Co Status: IIGL	Reviewer(s): Linda Bird
	Authors: Diane Barrios, Marcelle Chapman, David Collier, Susan Eckler-Kerns, Rozelyn Hayes, Jessica Kaimo, David Koonce, Eula Quailes, John Steiniger, Genetta Williams	Disposition Date: 10/20/2008

Date Submitted: 10/14/2008	Disposition Status: Accepted For Informational Purposes
	Implementation Date:

Implementation Date Requested: 01/01/2009

State Filing Description:

General Information

Project Name: SNCTU-2001

Project Number:

Requested Filing Mode: Informational

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/20/2008

State Status Changed: 10/20/2008

Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: This filing has been
submitted to our Domicile State, New Jersey.

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

SERFF Tracking Number: PRUD-125850202 State: Arkansas
Filing Company: The Prudential Insurance Company of America State Tracking Number: 40569
Company Tracking Number: SNCTU-2001-JSAR
TOI: L04I Individual Life - Term Sub-TOI: L04I.215 Specified Age or Duration -
Fixed/Indeterminate Premium - Joint (Last Survivor)

Product Name: SNCTU-2001
Project Name/Number: SNCTU-2001/

Filing Description:

In Re: The Prudential Insurance Company of America

Company # 68241

Individual Life

Form Numbers: SNCTU-2001

Informational Filing

Dear Commissioner:

For informational purposes, we are notifying you of a change to use the 2001 CSO mortality table for the referenced policy form.

Form SNCTU-2001 is a Level Benefit Three Year Term Policy with increasing premiums, for which the death benefit is payable on the death of the second insured to die. There are no provisions for conversion or renewal. This form was approved on 9/10/2001.

The CSO mortality table is not specified in this policy form and there are no changes to any of the contract provisions. The premium rates are not changing. Copies of the approved form and updated actuarial material is enclosed.

If you have any questions, please call me toll-free at (888)-800-8244, or contact me via e-mail at John.Steiniger@Prudential.com.

Company and Contact

Filing Contact Information

John Steiniger, Second Vice President	John.Steiniger@Prudential.com
Individual Insurance Group	(973) 802-6104 [Phone]
Newark, NJ 07102-2992	(973) 367-8134[FAX]

Filing Company Information

The Prudential Insurance Company of America CoCode: 68241

State of Domicile: New Jersey

SERFF Tracking Number: PRUD-125850202 State: Arkansas
Filing Company: The Prudential Insurance Company of America State Tracking Number: 40569
Company Tracking Number: SNCTU-2001-JSAR
TOI: L04I Individual Life - Term Sub-TOI: L04I.215 Specified Age or Duration -
Fixed/Indeterminate Premium - Joint (Last
Survivor)

Product Name: SNCTU-2001
Project Name/Number: SNCTU-2001/

751 Broad Street
Newark, NJ 07102-3777
(973) 802-6000 ext. [Phone]

Group Code: 304
Group Name:
FEIN Number: 22-1211670

Company Type: Life
State ID Number:

SERFF Tracking Number: PRUD-125850202 State: Arkansas
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Product Name: SNCTU-2001
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: The filing fee is \$50.00 per filing
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Prudential Insurance Company of America	\$50.00	10/14/2008	23182505

SERFF Tracking Number:	PRUD-125850202	State:	Arkansas
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Product Name:	SNCTU-2001		
Project Name/Number:	SNCTU-2001/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Linda Bird Informational Purposes		10/20/2008	10/20/2008

<i>SERFF Tracking Number:</i>	<i>PRUD-125850202</i>	<i>State:</i>	<i>Arkansas</i>
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Disposition

Disposition Date: 10/20/2008

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PRUD-125850202 State: Arkansas

Filing Company: The Prudential Insurance Company of America State Tracking Number: 40569

Company Tracking Number: SNCTU-2001-JSAR

TOI: L04I Individual Life - Term Sub-TOI: L04I.215 Specified Age or Duration - Fixed/Indeterminate Premium - Joint (Last Survivor)

Product Name: SNCTU-2001

Project Name/Number: SNCTU-2001/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	SNCTU-2001 Policy		Yes
Supporting Document	Reserves		Yes

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Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: PRUD-125850202 State: Arkansas
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TOI: L04I Individual Life - Term Sub-TOI: L04I.215 Specified Age or Duration -
Fixed/Indeterminate Premium - Joint (Last
Survivor)
Product Name: SNCTU-2001
Project Name/Number: SNCTU-2001/

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/08/2008
Comments:
Attachment:
AR Cert of Compliance.pdf

Review Status:

Satisfied -Name: Application 10/08/2008
Comments:
ORD 96200-98 was approved on 10/27/1998

Review Status:

Satisfied -Name: SNCTU-2001 Policy 10/10/2008
Comments:
Attached is our SNCTU-2001 Policy
Attachment:
SNCTU-2001 AR Policy - Revised page 3.pdf

Review Status:

Satisfied -Name: Reserves 10/14/2008
Comments:
Attached are our reserves
Attachment:
SNCTU-2001 Basic Reserves.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: The Prudential Insurance Company of America

Form Number(s): SNCTU-2001

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

John Steiniger

Name

Second Vice President

Title

10/3/08

Date



Prudential

The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102-3777

Insured JOHN DOE
Insured MARY DOE

XX XXX XXX Policy Number
OCT 1, 2001 Contract Date

Agency R-NK 1

Survivorship Term Life Policy. Provides a level benefit. Survivorship insurance payable upon death of second Insured to die within stated term period. Premiums payable during either Insured's lifetime for stated premium period. Premiums will increase annually as shown under Schedule of Premiums on page 3. Not convertible or renewable. Non-participating.

We will pay the beneficiary the death benefit described in this contract promptly if we receive due proof that both Insureds died in the term period (but proof of the first death must be given to us when it occurs). We make this promise subject to all the provisions of this contract. The term period starts on the contract date. The anniversary at the end of the term period is part of the term period.

If there is ever a question about this contract, just see a Prudential representative or contact one of our offices.

10-Day Right to Cancel Contract.—If you return this contract to us no later than 10 days after you receive it, we will refund your money promptly. The contract will be canceled from the start. All you have to do is take it or mail it to one of our offices or to the representative who sold it to you.

Signed for Prudential.

SPECIMEN ★

Secretary

SPECIMEN ★

President

PLEASE READ YOUR POLICY CAREFULLY; it is a legal contract between you and Prudential.

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A copy of the application and any riders or endorsements can be found at the end of the contract.

CONTRACT DATA

Insured(s)

(1) [JOHN DOE] [Male], [Issue Age 35]
(2) [MARY DOE] [Female], [Issue Age 35]

Rating Class

Insured (1) [Standard]
Insured (2) [Standard]

Basic Contract Information

Policy Number [XX XXX XXX]
Contract Date [October 1, 2001]
Term Period 3 years
Premium Period 3 years
Beneficiary [See beneficiary provision attached]

Survivorship Insurance

Basic Amount [\$100,000.00]

Schedule of Premiums

Contract premiums are due on the contract date and every 12 months after that date. The annual premium is [\$100.00] and changes as shown below.

Premium Change Date(s)	Total Annual Contract Premiums
[OCT 1, 2002]	[\$100.00]
[OCT 1, 2003]	[\$100.00]

Each contract premium for the basic amount includes a policy fee of \$85.00.

END OF CONTRACT DATA

ENDORSEMENTS

(Only we can endorse this contract.)

DEFINITIONS

We, our, us and Prudential.—The Prudential Insurance Company of America.

You and Your.—The owner(s) of the contract.

Insured.—A person named as an Insured on the first page. He or she need not be the owner.

Issue date.—Same as the contract date.

Anniversary or contract anniversary.—The same day and month as the contract date in each later year.

Contract year.—A year that starts on the contract date or on an anniversary.

THE CONTRACT

Entire Contract	This policy and any attached copy of an application, including an application requesting a change, form the entire contract. We assume that all statements in an application are made to the best of the knowledge and belief of the person(s) who make them; in the absence of fraud, they are deemed to be representations and not warranties. We rely on those statements when we issue the contract and when we change it. We will not use any statement, unless made in an application, to try to void the contract, to contest a change, or to deny a claim.
Contract Modifications	Only a Prudential officer with the rank or title of vice president may agree to modify this contract, and then only in writing.
Incontestability	Except for non-payment of premium, we will not contest this contract after it has been in force during the lifetime of both Insureds for two years from the issue date. At the end of the second contract year we will mail you a notice requesting that you tell us if either Insured has died. Failure to tell us of the death of an Insured will not avoid a contest, if we have a basis for one, even if premium payments continue to be made.

OWNERSHIP

Unless a different owner is named in the application, the owner(s) of the contract are the Insureds jointly or the survivor of them. If a different owner is named, we will show that owner in an endorsement to the contract. If this contract is owned jointly, the exercise of rights under this contract must be made by both jointly. This ownership arrangement will remain in effect unless you ask us to change it.

You may change the ownership of the contract by sending us a request in a form that meets our needs. We may ask you to send us the contract to be endorsed. If we receive your request in a form that meets our needs, and the contract if we ask for it, we will file and record the change, and it will take effect as of the date you signed the request.

While either of the Insureds is living, the owner(s) is entitled to any contract benefit and value, and to the exercise of any right and privilege granted by the contract or by us.

DEATH BENEFITS

If the second Insured to die dies in the term period, we will pay a benefit at that Insured's death (except as we state in the Suicide Exclusion) if this contract is in force at the time of death; that is, the initial premium has been paid and no premium is past due beyond the 31 day grace period we describe under Premium Payment.

The benefit payable at the second Insured's death will be equal to the Survivorship Insurance as described on a contract data page, plus a return of any unearned premium paid by you less any past due premium.

This contract may provide additional benefits which may be payable on either the first or second death. If it does, each benefit will be listed on a contract data page, and a form describing the benefit and the conditions under which it is payable will be included in this contract. Any such benefit will be payable only if the contract is in force, unless the form that describes the benefit states otherwise.

Unearned Premium	When we pay a death benefit we will return that part of the last premium paid by you for that benefit that covers the period after the date of death.
Interest on Death Benefit	Any death benefit described above will be credited with interest from the date of death at a rate declared by Prudential or in accordance with applicable laws.
Suicide Exclusion	If either Insured, whether sane or insane, dies by suicide within two years from the Issue Date, this contract will end and we will return the premiums paid. If there is a surviving Insured, we will make a new contract available on the life of that Insured. The issue age, Contract Date and the Insured's underwriting classification will be the same as they are in this contract. The amount of coverage will be the lesser of (1) this contract's Survivorship Insurance Basic Amount, and (2) the maximum amount allowed by our rules in use on the Contract Date for contracts covering a single life. The new contract will not take effect unless all premiums due since the Contract Date are paid to us within 31 days after we notify you of the availability of the new contract. We will set the premiums for the new contract in accordance with our rules in use on the Contract Date.
Simultaneous Death	If both Insureds die while this contract is in force and we find there is a lack of sufficient evidence that they died other than simultaneously, we will assume that the older Insured died first.
Method of Payment	You may choose to have any death benefit paid in a single sum or under an optional mode of settlement (see Settlement Options).

BENEFICIARY

You may designate or change a beneficiary by sending us a request in a form that meets our needs. We may ask you to send us the contract to be endorsed. If we receive your request, and the contract if we ask for it, we will file and record the change and it will take effect as of the date you signed the request. But if we make any payment(s) before we receive the request, we will not have to make the payment(s) again. Any beneficiary's interest is subject to the rights of any assignee we know of. If a beneficiary has not been designated, or no beneficiary has survived the last Insured to die, the death benefit will be paid in one sum to the owner of this contract.

Before we make a payment, we have the right to decide what proof we need of the identity, age or any other facts about any persons designated as beneficiaries. If beneficiaries are not designated by name and we make payment(s) based on that proof, we will not have to make the payment(s) again.

CHANGE IN PLAN

You may be able to have this contract changed to another plan of life insurance. Any change will be made only if we consent, and will be subject to conditions and charges that are then determined.

PREMIUM PAYMENT

- | | |
|----------------------------|--|
| Payment of Premiums | The schedule of premiums shows the amounts of the premiums and when they are due. These premiums are due only while an Insured is living and only during the premium period. |
| Grace Period | We grant a 31-day grace period for paying each premium except the first one. If the premium has not been paid by its due date, the contract will stay in force during the grace period. If the premium has not been paid when its grace period is over, the contract will end and have no value. |

REINSTATEMENT

You may reinstate this contract after the grace period of a past due premium if: the term period has not ended; both Insureds are alive or one Insured is alive and the grace period of the past due premium ended after the death of the other Insured; the premium payment is not past due more than five years; and you prove to us that any Insured who was living at the end of the grace period is insurable for the contract.

You must pay us all premiums in arrears; we may also charge compound interest at a rate of up to 6% per year.

GENERAL PROVISIONS

- Currency** Any money we pay, or that is paid to us, must be in United States currency.
- Misstatement of Age** If an Insured's stated age is not correct, we will change each benefit and any amount to be paid to what the premium would have bought for the correct age.
- The Schedule of Premiums may show that premiums change or stop on a certain date. We may have used that date because an Insured would attain a certain age on that date. If we find that the issue age was wrong, we will correct that date.
- Cancellation** If you ask us in a form that meets our needs and while no premium is past due, we will cancel this contract on the date we receive your request. On that date, the contract will end and have no value. We will return that part of the last premium paid by you that covers the period after the cancellation date.
- Assignment** We will not be deemed to know of an assignment unless we receive it, or a copy of it. We are not obliged to see that an assignment is valid or sufficient. This contract may not be assigned to any employee benefit plan without our consent.
- Non-Participating** This contract will not share in our profits or surplus earnings. We will pay no dividends on it.

SETTLEMENT OPTIONS

Options Described	<p>You may choose to have any death benefit paid in a single sum or under one of the optional modes of settlement described below.</p> <p>If the person who is to receive the proceeds of this contract wishes to take advantage of one of these optional modes, we will be glad to furnish, on request, details of the options we describe below or any others we may have available at the time the proceeds become payable.</p>
Option 1 (Instalments for a Fixed Period)	We will make equal payments for up to 25 years. The Option 1 Table shows the minimum amounts we will pay.
Option 2 (Life Income)	We will make equal monthly payments for as long as the person on whose life the settlement is based lives with payments certain for 120 months. The Option 2 Table shows the minimum amounts we will pay. But, we must have proof of the date of birth of the person on whose life the settlement is based.
Option 3 (Interest Payment)	We will hold an amount at interest. We will pay the interest annually, semi-annually, quarterly, or monthly.
Option 4 (Instalments of a Fixed Amount)	We will make equal annual, semi-annual, quarterly, or monthly payments for as long as the available proceeds provide.
Option 5 (Non-Participating Income)	We will make payments like those of any annuity we then regularly issue that: (1) is based on United States currency; (2) is bought by a single sum; (3) does not provide for dividends; and (4) does not normally provide for deferral of the first payment. Each payment will be at least equal to what we would pay under that kind of annuity with its first payment due on its contract date. If a life income is chosen, we must have proof of the date of birth of any person on whose life the option is based. Option 5 cannot be chosen more than 30 days before the due date of the first payment.
Interest Rate	Payments under Options 1, 3 and 4 will be calculated assuming an effective interest rate of at least 3% a year. We may include more interest.

SETTLEMENT OPTIONS TABLES

OPTION 1 TABLE

MINIMUM AMOUNT OF MONTHLY PAYMENT FOR EACH \$1,000, THE FIRST PAYABLE IMMEDIATELY	
Number of Years	Monthly Payment
1	\$84.65
2	43.05
3	29.19
4	22.27
5	18.12
6	15.35
7	13.38
8	11.90
9	10.75
10	9.83
11	9.09
12	8.46
13	7.94
14	7.49
15	7.10
16	6.76
17	6.47
18	6.20
19	5.97
20	5.75
21	5.56
22	5.39
23	5.24
24	5.09
25	4.96
Multiply the monthly amount by 2.989 for quarterly, 5.952 for semi-annual or 11.804 for annual.	

OPTION 2 TABLE

MINIMUM AMOUNT OF MONTHLY PAYMENT FOR EACH \$1,000, THE FIRST PAYABLE IMMEDIATELY					
AGE LAST BIRTHDAY	KIND OF LIFE INCOME		AGE LAST BIRTHDAY	KIND OF LIFE INCOME	
	10-Year Certain	Instalment Refund		10-Year Certain	Instalment Refund
10 and under	\$3.15	\$3.14	45	\$3.94	\$3.88
11	3.16	3.15	46	3.99	3.92
12	3.17	3.16	47	4.03	3.97
13	3.18	3.17	48	4.08	4.01
14	3.19	3.18	49	4.14	4.06
15	3.20	3.19	50	4.19	4.11
16	3.21	3.21	51	4.25	4.16
17	3.23	3.22	52	4.31	4.21
18	3.24	3.23	53	4.37	4.27
19	3.25	3.24	54	4.44	4.33
20	3.27	3.26	55	4.51	4.39
21	3.28	3.27	56	4.58	4.46
22	3.30	3.29	57	4.66	4.53
23	3.32	3.30	58	4.74	4.60
24	3.33	3.32	59	4.83	4.67
25	3.35	3.34	60	4.92	4.75
26	3.37	3.36	61	5.02	4.84
27	3.39	3.37	62	5.12	4.92
28	3.41	3.39	63	5.22	5.02
29	3.43	3.41	64	5.34	5.11
30	3.45	3.43	65	5.45	5.22
31	3.48	3.46	66	5.58	5.33
32	3.50	3.48	67	5.71	5.44
33	3.52	3.50	68	5.84	5.56
34	3.55	3.53	69	5.99	5.69
35	3.58	3.55	70	6.13	5.82
36	3.61	3.58	71	6.29	5.97
37	3.64	3.61	72	6.45	6.12
38	3.67	3.64	73	6.62	6.27
39	3.70	3.67	74	6.79	6.44
40	3.74	3.70	75	6.96	6.62
41	3.78	3.73	76	7.14	6.81
42	3.81	3.77	77	7.33	7.01
43	3.85	3.80	78	7.51	7.22
44	3.90	3.84	79	7.70	7.44
			80 and over	7.88	7.67



Prudential

Application for Life Insurance or Policy Change

☒ The Prudential Insurance Company of America
☐ Pruco Life Insurance Company, a subsidiary of
 The Prudential Insurance Company of America
 Corporate Offices, Newark, New Jersey

Part 1

Policy number XXXXXXXXXX

☐ Check here if policy change.

A About the Primary Proposed Insured

1. Name of primary proposed insured (or current insured person, if policy change)

John Doe

(First name, middle initial, last name)

2. Social Security number

XXX-XX-XXXX

3. Sex ☐ female ☒ male

4. Marital status

☐ single

☒ married

☐ widowed

☐ separated

☐ divorced

5. Date of birth

6/10/66

6. Age

35

month day year

7. State of birth (country if not U.S.)

(Name of State)

8. Billing address

123 Main Street, AnyCity, Any State XXXXX
 (street, city, state, ZIP)

9. Home address

(if different)

(street, city, state, ZIP)

10. Home telephone number

(XXX) XXX-XXXX

11. Business telephone number

(XXX) XXX-XXXX

12. Current employer

ABC Company

13. List all existing life insurance coverage. ☒ Check here if none.

Company	Amount	Year issued	Type of insurance	To be replaced?
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No

B All Other Proposed Insureds

(Include
applicant if
requesting
Applicant's
Waiver of
Premium
[AWP]
Benefit)

Name
(first, initial, last)

relationship to primary
proposed insured

sex
(F/M)

date of birth
(M/D/Y)

age

state of birth
(country if not U.S.)

total life insurance
in all companies

C Coverage Information

1. Plan of insurance Survivorship Term Life
If applicable to the plan, check one. ☒ Level Death Benefit ☐ Variable Death Benefit
2. Initial amount of insurance \$ 100,000 --
3. Supplementary benefits and riders
- | | |
|--|---|
| <input type="checkbox"/> Waiver of Premium | <input type="checkbox"/> Accidental Death Benefit \$ _____ |
| <input type="checkbox"/> Applicant's Waiver of Premium | <input type="checkbox"/> Option to Purchase Additional Insurance (OPA) \$ _____ |
| <input type="checkbox"/> Automatic Premium Loan | <input type="checkbox"/> Option to Purchase Paid-up Life Insurance Additions |
| <input type="checkbox"/> Acceleration of Death Benefits (Living Needs Benefit) | (include details in section G, <i>Special Requests</i>) |

Other riders and benefits (indicate amount where applicable) _____

D Beneficiaries 1. Beneficiary information and Ownership
(If trust, provide name of trust, trustee and date of trust)

Name	Relationship to primary proposed insured	Age
Primary (Class 1) <u>The Estate of the</u>		
<u>Second Insured to Die</u>		
Contingent (Class 2)		

2. Is the policyowner someone other than the primary proposed insured? ☐ Yes ☒ No
(If Yes, provide information requested below.)

Name _____ Date of birth / /
(First name, middle initial, last name) month day year

Address _____
(street, city, state, ZIP)

E Payment Information

- 1a. Within the past 90 days, has any proposed insured been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason other than for normal pregnancy or well-baby care? ☐ Yes ☒ No
- b. Within the past 12 months, has any proposed insured received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin)? ☐ Yes ☒ No
2. Is a medical examination required on the primary proposed insured? ☒ Yes ☐ No
second proposed insured? ☐ Yes ☒ No
3. Premium payment mode (collect full modal premium if prepaid)
- | | | | |
|--|---|---|----------------------------------|
| <input checked="" type="checkbox"/> Annual | <input type="checkbox"/> Semiannual | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Electronic Funds Transfer (EFT) | <input type="checkbox"/> Payroll Budget | <input type="checkbox"/> Government Allotment | |
4. Amount of prepayment submitted with this application \$ 50.00 ^{joint} (include any unscheduled premium payments)
☐ None (must be None if 1a or 1b is Yes, except for Gibraltar (GIB) products)
5. Date prepayment collected, 10/1/2001
month day year

F Replacement For any proposed insured, would this insurance replace or cause a change in any existing insurance or annuity in any company? (If Yes, enclose all required replacement forms.)☐ Yes ☒ No**G Special Requests**

Consider only with application on Mary Doe, Date of Bir
6-1-66
Owner- The Insureds Jointly or Survivor

Part 1

Application for Life Insurance or Policy Change

- H Background on Proposed Insureds**
1. Has either the primary proposed insured or second proposed insured (if any) ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? *(If Yes, provide date when last used and indicate all types of products.)* ☐ Yes ☒ No
- | | Date (mo., yr.) | Product(s) |
|--------------------------|-----------------|------------|
| Primary proposed insured | | |
| Second proposed insured | | |
2. What are the occupation and duties of the primary proposed insured? MANAGER + ADMINISTRATIVE DUTIES
3. Within the last two years, has any proposed insured done or does he or she plan to do the following:
- a. operate or have any duties aboard an aircraft, glider, balloon or similar device? ☐ Yes ☒ No
(If Yes, complete Aviation Questionnaire.)
- b. participate in hazardous sports, such as auto, motorcycle, snowmobile or powerboat competitions/exhibitions, scuba diving, mountain climbing, parachuting, skydiving or any other such sport or hobby? *(If Yes, complete Avocation Questionnaire.)* ☐ Yes ☒ No
4. Is any proposed insured applying for or requesting reinstatement or policy change(s) of any other life or health insurance policy? *(If Yes, provide insurance company, policy plan and amount.)* ☐ Yes ☒ No
5. Has any proposed insured been convicted of, or currently charged with, the commission of any criminal offense – other than the violation of a motor vehicle law – within the last 10 years? ☐ Yes ☒ No
(If Yes, provide details.)
6. a. Driver's license number and state of issue of primary proposed insured XXXXXX-XXXXXX-XXXXXX (Name of State)
- b. In the last three years, has any proposed insured
- (1) had a driver's license denied, suspended or revoked? ☐ Yes ☒ No
- (2) been convicted of or cited for
- (a) three or more moving violations? ☐ Yes ☒ No
- (b) driving under the influence of alcohol or drugs? ☐ Yes ☒ No
- (3) been involved as a driver in two or more auto accidents? ☐ Yes ☒ No
(If Yes to any of the above, provide details, including type of violation, accident, or reason for denial, suspension or revocation.)
7. Does any proposed insured plan to live or travel outside the United States or Canada within the next 12 months? *(If Yes, list countries and purpose and duration of each trip.)* ☐ Yes ☒ No

- I Additional Coverage** *Complete only if this is an application for additional coverage on a person already covered by a Prudential or Pruco policy with an application date within three months of the date of this application.*
- To the best of your knowledge, has the health or the mental or physical condition of any person proposed for insurance changed since the answers and statements were given in the application included in policy number _____? ☐ Yes ☒ No
(If Yes, complete the appropriate Part 2 Medical Information section.)

- J Changes** Changes made by the Company (not applicable in New Mexico or West Virginia).

K Physician Information Primary proposed insured
Physician last consultedName DR. William SmithAddress 23 Main Street
(street, city, state, ZIP)Any City, Any State XXXXXTelephone number (XXX) XXX-XXXX Date last seen 10/1/97
month day yearReason last seen ColdPrimary physicianName Dr. William SmithAddress 23 Main Street
(street, city, state, ZIP)Any City, Any State XXXXXTelephone number (XXX) XX-XXXX Date last seen 10/1/97
month day yearReason last seen Cold

Second proposed insured or applicant for Applicant's Waiver of Premium (AWP)

Physician last consulted

Name _____

Address _____
(street, city, state, ZIP)Telephone number () _____ Date last seen / /
month day year

Reason last seen _____

Primary physician

Name _____

Address _____
(street, city, state, ZIP)Telephone number () _____ Date last seen / /
month day year

Reason last seen _____

L Physical Measurements

	Height	Weight
Primary proposed insured	5'11"	180
Second proposed insured		
AWP applicant		

M Category II 1. Family recordChanges
and Plans
other than
Gibraltar
(GIB)

	Current age or age at death	Year and cause of death		Current age or age at death	Year and cause of death
Father	65		Mother	65	
Brother	30		Sister	25	
Brother			Sister		
Brother			Sister		

2. Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for

- a. chest pain or any disorder of the heart or blood vessels? ☐ Yes ☒ No
- b. high blood pressure? ☐ Yes ☒ No
- c. cancer, tumor, leukemia, melanoma or lymphoma? ☐ Yes ☒ No
- d. diabetes or high blood sugar? ☐ Yes ☒ No
- e. mental or psychiatric illness? ☐ Yes ☒ No
- f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? (**Maine:** this question may be answered No if an individual has tested HIV positive and does not have symptoms of the disease AIDS such as dry coughs, skin lesions, weakness, fatigue, weight loss or loss of appetite.) ☐ Yes ☒ No
- g. infection caused by the Human Immunodeficiency Virus (HIV)? (**Not applicable in California, Connecticut and Maine. Wisconsin:** AIDS virus HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site is confidential and need not be revealed on this application.) ☐ Yes ☒ No
- h. any sexually transmitted diseases? ☐ Yes ☒ No
- i. asthma or any disorder of the lungs? ☒ Yes ☒ No
- j. any disorder of the brain or nervous system? ☐ Yes ☒ No
- k. hepatitis or any disorder of the liver, stomach or intestines? ☐ Yes ☒ No
- l. any disorder of the kidney or urinary tract? ☐ Yes ☒ No

3. Is anyone proposed for coverage currently taking prescription medication?

☐ Yes ☒ No

4. Other than above, has anyone proposed for coverage

- a. been a patient in a hospital or other medical facility? ☐ Yes ☒ No
- b. in the last five years, had or been advised to have surgery, medical tests (other than HIV) or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc.? ☐ Yes ☒ No

5. Has anyone proposed for coverage

- a. used, or is he or she now using, cocaine, amphetamines, marijuana, heroin or other drugs, except as prescribed by a member of the medical profession? ☐ Yes ☒ No
- b. had or been advised to have treatment or counseling for alcohol or drug use? ☐ Yes ☒ No

6. Does anyone proposed for coverage have any disease, disorder or condition not previously mentioned? ☐ Yes ☒ No7. Has anyone proposed for coverage had life or health insurance declined, postponed or issued with an increased premium? (**Missouri:** this question may be answered No if an individual has been declined for coverage.) ☐ Yes ☒ No8. Is anyone proposed for coverage currently unable to perform his or her normal daily activities or all normal occupational duties on a full-time basis at the customary place of employment? ☐ Yes ☒ No9. Has anyone proposed for coverage requested or received disability or compensation benefits? ☐ Yes ☒ No

(continued on next page)

Name, address and telephone number of medical professionals and hospitals

10/97

Dr. Wm. Smith

23 Main Street

Any City, Any State

~~XXXXXXXXXX~~

For additional medical details, use another application.

Terms and Conditions

The words "I" and "my" refer to the primary proposed insured and policyowner or applicant, if other than the primary proposed insured. The word "Company" refers to the company checked at the beginning of this application.

Unless I have specified a policy date or special payment plan (e.g., government allotment, payroll budget) in this application, I understand that if the initial premium is not paid with this request for coverage, the policy will become effective when all of the following conditions are met:

- the policy is issued, delivered and I accept it,
- the health of all persons proposed for insurance remains as stated in the application and
- the first premium is paid in full and the check or other form of payment is good and can be collected.

If the Company enters any change in section J, I approve the change by accepting the policy unless the law requires written consent to changes. No Company representative can make or change a policy, or waive any of the Company's rights or requirements.

The Company will pay the beneficiary named in the application (or in the policy if requesting a policy change and no beneficiary has been named in the application) any applicable insurance benefit either at the death of the primary insured or at the death of an insured child after the death of the primary insured if there is no insured spouse.

For policy changes, the existing policyowner and beneficiary designation will be used unless a new policyowner or beneficiary designation is provided in this application.

The policyowner is either the primary proposed insured or the applicant unless a different policyowner is named in the application. This is subject to any provisions for the automatic transfer of ownership stated in the policy.

If joint policyowners are named, in the event of the death of one policyowner, the survivor(s) shall be the policyowner(s), unless otherwise specified.

Signatures

I certify, affirm and understand the following:

- To the best of my knowledge and belief, the statements in this application, as well as any forms that the Company designates to be part of the application and that are attached to the policy, are complete, true and correctly recorded.
- Except for failure to pay premium or fraud, the Company will not contest the validity of this policy or change request after it has been in force during the insured's lifetime for two years from the date it takes effect.
- I will inform the Company of any changes in my or any proposed insured's health, mental or physical condition, or of any changes to any answers on this application, prior to or upon delivery of this policy.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the brochure (ORD 87246).
- I have received and read the Terms and Conditions shown above and the Important Notice About Your Application for Insurance.
- I believe this policy meets my insurance needs and financial objectives. For a variable product: I acknowledge receipt of a current prospectus for the policy. I understand that the policy's value and death benefit may vary depending on the policy's investment experience.
- My original signature has been affixed to this application, the original application will be retained by the Company and I will receive a copy identical in form and substance to the original, attached to my policy.

(continued on next page)

- Not applicable in Arizona, Oklahoma, Oregon, and Vermont:

Any person who knowingly and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company:

- may have committed fraud, or may have violated state law,
- Arkansas, District of Columbia, Hawaii, Louisiana, Maine, New Mexico, and Virginia: may be subject to fines, denial of insurance benefits, or confinement in prison,
- Colorado: penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signed at (Name of City, State) on 10/1/2001
(city, state) month day year

Signature of primary proposed insured, if age 8 or over,
or of currently insured person, if policy change

X John Doe

Signature of spouse (applicable in
South Carolina, if proposed for coverage.)

X _____

Signature of policyowner (if different from the primary proposed
insured) or of existing policyowner if a policy change. If the
policyowner is a firm or corporation, give that company's name
and have an officer sign below.

X John Doe - Mary Doe

Signature and title of officer of firm or corporation

X _____

Signature of applicant, if different from primary proposed insured
or policyowner

X _____

Signature of beneficiary, if policy change and rights
are limited

X _____

Signature of witness
(Licensed Writing Representative must witness.)

X John Doe

Licensed Writing Representative's Certification

Do you have any information, other than that stated in this application, which indicates that any proposed insured may replace or change any current insurance or annuity in any company?

☐ Yes ☐ No

Signature of Writing Representative

X _____



Prudential

Application for Life Insurance or Policy Change

☒ The Prudential Insurance Company of America
☒ Pruco Life Insurance Company, a subsidiary of
 The Prudential Insurance Company of America
 Corporate Offices, Newark, New Jersey

Part 1

Policy number XXX XX XXXX

☐ Check here if policy change.

A About the Primary Proposed Insured

1. Name of primary proposed insured (or current insured person, if policy change)

Mary Doe
 (First name, middle initial, last name)

2. Social Security number XXX-XX-XXXX

3. Sex ☒ female ☐ male

4. Marital status ☐ single ☒ married ☐ widowed ☐ separated ☐ divorced

5. Date of birth 6 / 16 / 66
 month day year

6. Age 35

7. State of birth (country if not U.S.) (Name of State)

8. Billing address 123 Main Street, Any City, Any State XXX
 (street, city, state, ZIP)

9. Home address
 (if different) (street, city, state, ZIP)

10. Home telephone number (XXX) XXX-XXXX

11. Business telephone number (XXX) XXX-XXXX

12. Current employer ABC Company

13. List all existing life insurance coverage. ☒ Check here if none.

Company	Amount	Year issued	Type of insurance	To be replaced?
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Yes <input type="checkbox"/> No

B All Other Proposed Insureds (Include applicant if requesting Applicant's Waiver of Premium [AWP] Benefit)

Name (first, initial, last)	relationship to primary proposed insured	sex (F/M)	date of birth (M/D/Y)	age	state of birth (country if not U.S.)	total life insurance in all companies

Part 1

G Coverage Information

1. Plan of insurance Survivorship Term Life
If applicable to the plan, check one. ☒ Level Death Benefit ☐ Variable Death Benefit
2. Initial amount of insurance \$ 100,000 --
3. Supplementary benefits and riders
- | | |
|--|--|
| <input type="checkbox"/> Waiver of Premium | <input type="checkbox"/> Accidental Death Benefit \$ _____ |
| <input type="checkbox"/> Applicant's Waiver of Premium | <input type="checkbox"/> Option to Purchase Additional Insurance (OPAI) \$ _____ |
| <input type="checkbox"/> Automatic Premium Loan | <input type="checkbox"/> Option to Purchase Paid-up Life Insurance Additions |
| <input type="checkbox"/> Acceleration of Death Benefits (Living Needs Benefit) | (include details in section G, Special Requests) |

Other riders and benefits (indicate amount where applicable) _____

D Beneficiaries

1. Beneficiary information and Ownership
(If trust, provide name of trust, trustee and date of trust)

Primary (Class 1)	Name	Relationship to primary proposed insured	Age
	Contingent (Class 2)		
	<u>The Estate of the</u>		
	<u>Second Insured to Die</u>		

2. Is the policyowner someone other than the primary proposed insured? ☐ Yes ☒ No
(If Yes, provide information requested below.)

Name _____ Date of birth / /
(First name, middle initial, last name) month day year

Address _____
(street, city, state, ZIP)

E Payment Information

- 1a. Within the past 90 days, has any proposed insured been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason other than for normal pregnancy or well-baby care? ☐ Yes ☒ No
- b. Within the past 12 months, has any proposed insured received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin)? ☐ Yes ☒ No
2. Is a medical examination required on the primary proposed insured? ☒ Yes ☐ No
second proposed insured? ☐ Yes ☒ No
3. Premium payment mode (collect full modal premium if prepaid)
- | | | | |
|--|---|---|----------------------------------|
| <input checked="" type="checkbox"/> Annual | <input type="checkbox"/> Semiannual | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Electronic Funds Transfer (EFT) | <input type="checkbox"/> Payroll Budget | <input type="checkbox"/> Government Allotment | |
4. Amount of prepayment submitted with this application \$ 50.00 1/2 joint (include any unscheduled premium payments)
☐ None (must be None if 1a or 1b is Yes, except for Gibraltar [GIB] products)
5. Date prepayment collected, 10/1/2001
month day year

F Replacement For any proposed insured, would this insurance replace or cause a change in any existing insurance or annuity in any company? (If Yes, enclose all required replacement forms.)☐ Yes ☒ No**G Special Requests**

Consider only with application on John Doe,
Date of Birth 6-10-66
Owner - The Insureds Jointly or Survivor

Part 1

Application for Life Insurance or Policy Change

- H Background on Proposed Insureds**
1. Has either the primary proposed insured or second proposed insured (if any) ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? (If Yes, provide date when last used and indicate all types of products.) ☐ Yes ☒ No
- | | Date (mo., yr.) | Product(s) |
|--------------------------|-----------------|------------|
| Primary proposed insured | | |
| Second proposed insured | | |
2. What are the occupation and duties of the primary proposed insured? MANAGER + ADMINISTRATIVE DUTIES
3. Within the last two years, has any proposed insured done or does he or she plan to do the following:
- a. operate or have any duties aboard an aircraft, glider, balloon or similar device? ☐ Yes ☒ No
(If Yes, complete Aviation Questionnaire.)
- b. participate in hazardous sports, such as auto, motorcycle, snowmobile or powerboat competitions/exhibitions, scuba diving, mountain climbing, parachuting, skydiving or any other such sport or hobby? (If Yes, complete Avocation Questionnaire.) ☐ Yes ☒ No
4. Is any proposed insured applying for or requesting reinstatement or policy change(s) of any other life or health insurance policy? (If Yes, provide insurance company, policy plan and amount.) ☐ Yes ☒ No
5. Has any proposed insured been convicted of, or currently charged with, the commission of any criminal offense – other than the violation of a motor vehicle law – within the last 10 years? ☐ Yes ☒ No
(If Yes, provide details.)
6. a. Driver's license number and state of issue of primary proposed insured XXXXX-XXXXX-XXXXX (Name of State)
- b. In the last three years, has any proposed insured
- (1) had a driver's license denied, suspended or revoked? ☐ Yes ☒ No
- (2) been convicted of or cited for
- (a) three or more moving violations? ☐ Yes ☒ No
- (b) driving under the influence of alcohol or drugs? ☐ Yes ☒ No
- (3) been involved as a driver in two or more auto accidents? ☐ Yes ☒ No
(If Yes to any of the above, provide details, including type of violation, accident, or reason for denial, suspension or revocation.)
7. Does any proposed insured plan to live or travel outside the United States or Canada within the next 12 months? (If Yes, list countries and purpose and duration of each trip.) ☐ Yes ☒ No

I Additional Coverage

Complete only if this is an application for additional coverage on a person already covered by a Prudential or Pruco policy with an application date within three months of the date of this application.

To the best of your knowledge, has the health or the mental or physical condition of any person proposed for insurance changed since the answers and statements were given in the application included in policy number _____?

☐ Yes ☒ No

(If Yes, complete the appropriate Part 2 Medical Information section.)

J Changes

Changes made by the Company (not applicable in New Mexico or West Virginia)

K Physician
Information

Primary proposed insured

Physician last consultedName DR. William SmithAddress 23 Main Street
(street, city, state, ZIP)Any City, Any State XXXXXTelephone number XXX XXX-XXX Date last seen 10/1/97
month day yearReason last seen ColdPrimary physicianName DR. William SmithAddress 23 Main Street
(street, city, state, ZIP)Any City, Any State XXXXXTelephone number XXX XXX-XXX Date last seen 10/1/97
month day yearReason last seen Cold

Second proposed insured or applicant for Applicant's Waiver of Premium (AWP)

Physician last consulted

Name _____

Address _____
(street, city, state, ZIP)Telephone number () _____ Date last seen / /
month day year

Reason last seen _____

Primary physician

Name _____

Address _____
(street, city, state, ZIP)Telephone number () _____ Date last seen / /
month day year

Reason last seen _____

L Physical
Measurements

	Height	Weight
Primary proposed insured	5'4"	110
Second proposed insured		
AWP applicant		

M Category II 1. Family recordChanges
and Plans
other than
Gibraltar
(GIB)

	Current age or age at death	Year and cause of death		Current age or age at death	Year and cause of death
Father	65		Mother	65	
Brother	30		Sister	30	
Brother			Sister		
Brother			Sister		

2. Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for

a. chest pain or any disorder of the heart or blood vessels?

☐ Yes ☒ No

b. high blood pressure?

☐ Yes ☒ No

c. cancer, tumor, leukemia, melanoma or lymphoma?

☐ Yes ☒ No

d. diabetes or high blood sugar?

☐ Yes ☒ No

e. mental or psychiatric illness?

☐ Yes ☒ No

f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? (Maine: this question may be answered No if an individual has tested HIV positive and does not have symptoms of the disease AIDS such as dry coughs, skin lesions, weakness, fatigue, weight loss or loss of appetite.)

☐ Yes ☒ No

g. infection caused by the Human Immunodeficiency Virus (HIV)? (Not applicable in California, Connecticut and Maine. Wisconsin: AIDS virus HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site is confidential and need not be revealed on this application.)

☐ Yes ☒ No

h. any sexually transmitted diseases?

☐ Yes ☒ No

i. asthma or any disorder of the lungs?

☒ Yes ☐ No

j. any disorder of the brain or nervous system?

☐ Yes ☒ No

k. hepatitis or any disorder of the liver, stomach or intestines?

☐ Yes ☒ No

l. any disorder of the kidney or urinary tract?

☐ Yes ☒ No

☐ Yes ☒ No

3. Is anyone proposed for coverage currently taking prescription medication?

4. Other than above, has anyone proposed for coverage

☐ Yes ☒ No

a. been a patient in a hospital or other medical facility?

b. in the last five years, had or been advised to have surgery, medical tests (other than HIV) or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc.?

☐ Yes ☒ No

5. Has anyone proposed for coverage

a. used, or is he or she now using, cocaine, amphetamines, marijuana, heroin or other drugs, except as prescribed by a member of the medical profession?

☐ Yes ☒ No

b. had or been advised to have treatment or counseling for alcohol or drug use?

☐ Yes ☒ No

6. Does anyone proposed for coverage have any disease, disorder or condition not previously mentioned? ☐ Yes ☒ No

7. Has anyone proposed for coverage had life or health insurance declined, postponed or issued with an increased premium? (Missouri: this question may be answered No if an individual has been declined for coverage.)

☐ Yes ☒ No

8. Is anyone proposed for coverage currently unable to perform his or her normal daily activities or all normal occupational duties on a full-time basis at the customary place of employment?

☐ Yes ☒ No

9. Has anyone proposed for coverage requested or received disability or compensation benefits?

☐ Yes ☒ No

(continued on next page)

M Category II
Changes
and Plans
other than
Gibraltar
(GIB)
(continued)

10. Details of "Yes" answers for questions 2-9

Question number
and name of proposed
insuredIndicate illness, hospitalization, reason
for checkup, medication and any advice or
treatment given by a medical professionalDates and
duration
of illnessName, address and telephone
number of medical
professionals and hospitals

2. i. John

Cold

10/97

Dr. Wm. Smith

23 Main Street

Any City, Any State

XXXXX

For additional medical details, use another application.

Terms and Conditions

The words "I" and "my" refer to the primary proposed insured and policyowner or applicant, if other than the primary proposed insured. The word "Company" refers to the company checked at the beginning of this application.

Unless I have specified a policy date or special payment plan (e.g., government allotment, payroll budget) in this application, I understand that if the initial premium is not paid with this request for coverage, the policy will become effective when all of the following conditions are met:

- the policy is issued, delivered and I accept it,
- the health of all persons proposed for insurance remains as stated in the application and
- the first premium is paid in full and the check or other form of payment is good and can be collected.

If the Company enters any change in section J, I approve the change by accepting the policy unless the law requires written consent to changes. No Company representative can make or change a policy, or waive any of the Company's rights or requirements.

The Company will pay the beneficiary named in the application (or in the policy if requesting a policy change and no beneficiary has been named in the application) any applicable insurance benefit either at the death of the primary insured or at the death of an insured child after the death of the primary insured if there is no insured spouse.

For policy changes, the existing policyowner and beneficiary designation will be used unless a new policyowner or beneficiary designation is provided in this application.

The policyowner is either the primary proposed insured or the applicant unless a different policyowner is named in the application. This is subject to any provisions for the automatic transfer of ownership stated in the policy.

If joint policyowners are named, in the event of the death of one policyowner, the survivor(s) shall be the policyowner(s), unless otherwise specified.

Signatures

I certify, affirm and understand the following:

- To the best of my knowledge and belief, the statements in this application, as well as any forms that the Company designates to be part of the application and that are attached to the policy, are complete, true and correctly recorded.
- Except for failure to pay premium or fraud, the Company will not contest the validity of this policy or change request after it has been in force during the insured's lifetime for two years from the date it takes effect.
- I will inform the Company of any changes in my or any proposed insured's health, mental or physical condition, or of any changes to any answers on this application, prior to or upon delivery of this policy.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the brochure (ORD 87246).
- I have received and read the Terms and Conditions shown above and the Important Notice About Your Application for Insurance.
- I believe this policy meets my insurance needs and financial objectives. For a variable product: I acknowledge receipt of a current prospectus for the policy. I understand that the policy's value and death benefit may vary depending on the policy's investment experience.
- My original signature has been affixed to this application, the original application will be retained by the Company and I will receive a copy identical in form and substance to the original, attached to my policy.

(continued on next page)

- Not applicable in Arizona, Oklahoma, Oregon, and Vermont:

Any person who knowingly and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company:

- may have committed fraud, or may have violated state law,
- Arkansas, District of Columbia, Hawaii, Louisiana, Maine, New Mexico, and Virginia: may be subject to fines, denial of insurance benefits, or confinement in prison,
- Colorado: penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signed at (Name of City, State) on 10/1/2001
(city, state) month day year

Signature of primary proposed insured, if age 8 or over,
or of currently insured person, if policy change

X Mary Doe

Signature of spouse (applicable in
South Carolina, if proposed for coverage.)

X _____

Signature of policyowner (if different from the primary proposed
insured) or of existing policyowner if a policy change. If the
policyowner is a firm or corporation, give that company's name
and have an officer sign below.

X Mary Doe - John Doe

Signature and title of officer of firm or corporation

X _____

Signature of applicant, if different from primary proposed insured
or policyowner

X _____

Signature of beneficiary, if policy change and rights
are limited

X _____

Signature of witness
(Licensed Writing Representative must witness.)

X John Doe

Licensed Writing Representative's Certification

Do you have any information, other than that stated in this application, which indicates that any proposed insured may replace or change any current insurance or annuity in any company?

☐ Yes ☐ No

Signature of Writing Representative

X _____

Survivorship Term Life Policy. Provides a level benefit. Survivorship insurance payable upon death of second Insured to die within stated term period. Premiums payable during either Insured's lifetime for stated premium period. Premiums will increase annually as shown under Schedule of Premiums on page 3. Not convertible or renewable. Non-participating.

Actuarial Memorandum

The Prudential Insurance Company of America Term Life Policy Form # SNCTU-2001

Description

This policy provides term joint life (2nd to die) insurance benefits for a period of three years. Premiums increase annually. This policy is not convertible or renewable. Benefits are level and guaranteed for the life of the policy. There are no cash values.

This is a non-participating policy.


Policy Reserves

Reserves are calculated using the 2001 CSO mortality table, age last birthday, male/female, smoker/non-smoker and an interest rate of 4%. The reserve method is the Commissioner's Reserve Valuation Method using the greater of unitary and segmented reserves as defined in NAIC Model Regulation 830 (Regulation XXX).

Deficiency Reserves

In the event that gross premiums are less than statutory net premiums, a minimum reserve is calculated. This minimum reserve is calculated using the 2001 CSO mortality table, age last birthday, smoker/non-smoker and an interest rate of 4%. The reserve method is the Commissioner's Reserve Valuation Method using the greater of unitary and segmented reserves (Regulation XXX) except that net premiums are replaced with gross premiums when the gross premium is less than the net premium. If the minimum reserves are greater than the basic policy reserves, then deficiency reserves are the difference between the minimum reserves and basic policy reserves. Finally, reserves are the max(basic + deficiency, cash value).

A sample calculation is attached.



Joseph E. Brennan, ASA, MAAA
October 01, 2008

Actuarial Memorandum - SNCTU-2001

Page 1

LifeMaster Audit Report

SNCTU-2001 US 38 PRU

Valuation File: YR3-FILINGTEST2.VMF
 Valuation Date: 12/31/2008
 Run Date: 8/26/2008
 Run Time: 10:37 a.m.
 Record Type: 00

PRUDENTIAL LIFE

Company Code: AZ
 Policy Number: L32000012
 Line of Business: OT
 Admin Plan Code: 001 02407 T 233
 LM Plan Code: 3YJNON R&C 23 T
 Phase Code: 0
 Sub Phase Code: 1
 Policy Status: Active (Premium Paying)
 Issue Date: 1/15/2008
 Paid to Date: 1/15/2009
 Annualized Gross Premiums: 100.00
 Amount Issued: 100000.00
 Amount Inforce: 100000.00
 Units: 100.0000

	Primary Insured	Secondary Insured
Issue Age	35	35
Sex Code	X	X
Risk Code	DD	DD
Class Code	00	00

VMF Record Level Detail

Premium Mode: 1 ("A")
 Ben Code: 0003
 Prem Code: 0003
 Prem Pattern Code: 0000
 Expense Group Field 1: PI
 Expense Group Field 2: AZ

Guaranteed Provisions Code: 3YR INC PREM NON R&C
 Death Benefit Definition: 3 YEAR
 Death Benefit Pattern: LEVEL
 Minimum Death Benefit Pattern: NONE
 Endowment/Coupon Definition: NONE
 Endowment/Coupon Pattern: NONE
 Premium Payment Definition: LIMITED PAY
 Premium Payment Pattern: NONE
 Premium Mode Definition: TERM ELITE/ESSEN
 Special Benefits: NONE

POLICY NUMBER: L32000012
 Statutory 1 Unitary Processing
 Statutory Valuation Code: ST XXXC S/N 2K1 233
 Terminal Reserve Method: REVISED XXX
 Mean Reserve Method: 19 MidT+UeP DAY.
 Equivalent Level Amount 100000.00
 Expense Allowance: 0.43

DUR	1000 qx	i	DEATH BENEFIT	PREMIUM PATTERN	TERMINAL RESERVE	NET VAL PREMIUM	INTEREST COST	BENEFIT COST	MEAN RESERVE
0					0.00 *				
1	0.0013	0.040000	100000.00	1.00000	0.00	0.1254	-0.0000	0.1254	0.00
2	0.0040	0.040000	100000.00	1.00000	0.00	0.5557	0.0031	0.3986	0.00
3	0.0072	0.040000	100000.00	1.00000	0.00	0.5557	0.0032	0.7194	0.00